INSTRUCTIONS – PHYSICIAN SURVEY

Please complete the survey and return it in the enclosed postage paid envelope. Please do not write your name on the survey. Thank you in advance for your help and cooperation with this important project.

1. For the questions in this survey, please indicate whether you are providing data for (check one):

   ☐ Yourself (a single physician)

   ☐ A Practice (a group of physicians)

2. What is the total number of physicians in this practice? _____

3. Please indicate the type of practice this is: (Check as many as apply)

   ☐ Academic/Teaching ☐ Community-Based Private Office ☐ Community Health Center
   ☐ Single specialty practice ☐ Multi-specialty practice ☐ Solo practice
   ☐ Integrated Delivery System
   ☐ Group practice
   ☐ Other (please specify): _____

4. Of the total number of patients in this practice, what percentage do you estimate are covered by:

   MassHealth/Medicaid: _____%
   Medicare: _____%
   Managed care: _____%
   Indemnity: _____%
   Workers' compensation: _____%
   Other: _____%

5. Please provide the following information for yourself and any physicians for whom you are answering:

	Gender	Specialty	Year graduated medical school	Hrs/week providing direct patient care
Physician #1	_____	_____	_____	_____
Physician #2	_____	_____	_____	_____
Physician #3	_____	_____	_____	_____
Physician #4	_____	_____	_____	_____
Physician #5	_____	_____	_____	_____
Physician #6	_____	_____	_____	_____

(Please use additional sheet if necessary)

6. Apart from medical emergencies, does this practice accept new patients regardless of their ability to pay?

   ☐ YES ☐ NO

(over)

7. Does this practice currently have patients who do not have health insurance?

   ☐ YES ☐ NO ☐ DON'T KNOW

8. If yes, what is your best estimate of the percentage of your practice's patients who do not have insurance at this time?

   _____%

9. Does this practice ever reduce or waive fees for patients who are uninsured and have financial hardship?

   ☐ YES ☐ NO

10. Does this practice have a formal mechanism for determining a patient's financial hardship?

    ☐ YES ☐ NO

11. Please describe this practice's financial hardship determination process.

    _____

    _____

12. Do you or a staff member inform patients about the availability of public assistance programs?

    ☐ YES ☐ NO

13. Do you, or a staff member, assist patients with determining MassHealth eligibility and/or completing a MassHealth application?

    ☐ YES ☐ NO

Please answer the following questions for the patients in your practice who have no health insurance (for whom you are unable to bill *any* third party for their care, including MassHealth) and for whom you provide services on a *free or discounted* basis due to financial hardship. Please exclude those patients who pay in full ("self-pay") out of their own pocket.

14. Please check the services and procedures that this practice has provided to uninsured patients on a free or discounted basis last year:

    ☐ Well Office Visits ☐ Sick Office Visits
    ☐ Family Planning Services ☐ Immunizations
    ☐ Laboratory Tests ☐ X-Rays
    ☐ Procedures (please specify): _____
    ☐ Other (please specify): _____

15. Please estimate the average *monthly* dollar amount this practice provided in free or discounted services to uninsured patients last year. Do not include the value of free drug samples: (NOTE: In calculating your estimate, please use your average third-party reimbursement amount as the basis for your answer. For example, if your usual office visit reimbursement is $50 and you reduced this fee to $25 for 5 patients and charged nothing for 1 patient, you provided $25 x 5 = $125 and $50 x 1 = $50 or $175 in free/discounted office visits).

☐ Well Office Visits:	$_____
☐ Sick Office Visits:	$_____
☐ Family Planning Services:	$_____
☐ Immunizations:	$_____
☐ Laboratory tests:	$_____
☐ X-Rays:	$_____
☐ Procedures (please specify): _____	$_____
☐ Other (please specify): _____	$_____
Total:	$_____

Please answer the following questions for the patients in this practice who may or may not have health insurance but who pay <u>in full</u> out of their own pocket ("self-pay") for the services you provide.

16. To the best of your knowledge, please state the primary reason why these patients "self-pay" for care.

- ☐ Lack of health insurance
- ☐ Health insurance doesn't cover service(s)
- ☐ Patient does not want service to be reported to insurance carrier
- ☐ Don't know
- ☐ Other (please specify): _____

17. Please check the services and procedures that this practice provided to "self-pay" patients last year:

- ☐ Well Office Visits
- ☐ Sick Office Visits
- ☐ Family Planning Services
- ☐ Immunizations
- ☐ Laboratory Tests
- ☐ X-Rays
- ☐ Procedures (please specify): _____
- ☐ Other (please specify): _____

(over)

18. Please estimate the average monthly dollar amount of services and supplies this practice provided to "self-pay" patients last year:

☐ Well Office Visits:	$_____
☐ Sick Office Visits:	$_____
☐ Family Planning Services:	$_____
☐ Immunizations:	$_____
☐ Laboratory tests:	$_____
☐ X-Rays:	$_____
☐ Procedures (please specify): _____	$_____
☐ Other (please specify): _____	$_____
Total:	$_____

19. Title of person completing the survey:

☐ Physician ☐ Administrator ☐ Other -- Please specify: _____

20. What is the ZIP code of the city or town in which this practice is located? _____

Please use this space to offer your comments or additional information on uninsured and "self-pay" patients encountered in this practice.

_____

_____

_____

_____

Thank you very much. Please return the completed survey in the postage paid envelope provided.
If envelope is misplaced, please return to:

Massachusetts Division of Health Care Finance & Policy
2 Boylston St.
Boston, MA 02116
Attn: HSMIG